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DEPARTMENT OF HEALTH SERVICES
Public Health

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TO: Each Supervisor

David Janssen
Chief Administrative Officer

FROM: Jonathan E. Fielding, M.D., M.P.H. JEFielding MD
Director of Public Health and Health Officer

SUBJECT: **SEPARATION OF PUBLIC AND PERSONAL HEALTH SERVICES**

At the request of Supervisor Knabe, I am providing my opinion on creating a separate Public Health Department and responding to the concerns raised in the November 22, 2005 memo from Dr. Garthwaite to you regarding the possible separation of Public and Personal Health Services.

As indicated in the CAO report of June 9, 2005, there are compelling reasons for a separate public health department. From my perspective the foremost reasons are to:

- Improve responsiveness to serious public health threats, including emerging infectious diseases and bioterrorism.
- Increase accountability of public health for protecting the health of all county residents by direct reporting to your Board.
- Ensure strong public health leadership through your direct involvement in the director's selection and performance appraisal.
- Assure priority attention of essential administrative support services to key public health goals.
- Assure that key financial and program issues that affect the public's health are brought to the attention of your Board.

Other important reasons include a distinct public health mission and the increasing size and complexity of public health responsibilities.

Creation of a separate Public Health Department would be consistent with best practice in other large municipalities, such as New York, Chicago, Houston and Miami/Dade.

With respect to Dr. Garthwaite's memo, I have the following comments:

Structural Competition

The memo expressed concern about overlap in services provided by the two departments, and that separate planning and budgeting processes could lead to gaps in patient care and competition for scarce resources.

Avoiding gaps for our patients is a top priority. Collaborative planning and coordination in budgeting are covered in the draft Memorandum of Understanding (MOU) between the departments. One reason that difficult issues have arisen between DHS and Mental Health is that the MOU between the departments is vague. Lessons learned from this relationship are being addressed in the development of the MOU between DHS and Public Health.

Today there is very little overlap between the direct services provided by DHS and Public Health. Public Health provides very few clinical services, restricted to TB, STD, and immunizations. Directly delivered clinical services comprise less than 7% of Public Health's $650+ million budget. Most of Public's Health's efforts are directed to broad, population-based strategies for protecting health, preventing disease, and promoting health and well being for everyone in Los Angeles County and for contracting with external providers for services to specific vulnerable populations, such as those with HIV and/or substance abuse problems.

With regard to the concern about competition for limited County dollars, Public Health activities already compete with other health, mental health, and social service needs. The difference is that currently, requests of the director of public health are filtered through the DHS director, who has the authority to decide whether any priority public health requests will reach the CAO and the Board. Thus, under the current structure, if Public Health feels a request for resources is essential for protection against pandemic influenza or bioterrorism, this will only reach the CAO and Board if the Director agrees. This may not be an impediment to critical requests reaching the Board when the DHS director is supportive of Public Health, but future DHS directors may not value PH as highly as the current director. As a separate department, the CAO and Board would decide directly on key budget issues.

Structural Collaboration

The memo stated that the conditions that led the Board to establish a single Department of Health Services in the early 1970's still stand. This is not my understanding. The focus of Public Health today is very different from the 1970's, with a much greater emphasis on population-based activities and very limited direct, clinical services. In the 1970's, Public Health operated the Comprehensive Health Centers and Health Centers, with DHS (formerly the Department of Charities) operating the hospitals. The argument to merge to reduce fragmentation and duplication was more pertinent in that scenario than it is today.

Contrary to the intent, the merging of departments at that time only resulted in modest service integration, as evidenced by the example that Personal Health and Public Health still use different data systems. Key to Public Health's charge is to infuse public health principles into the delivery of care, and DHS shares this value. Relatively recently, DHS and Public Health co-chaired a task force to improve preventive measures, such as promoting smoking cessation and increasing immunizations, in DHS facilities. The draft MOU specifies that this joint task force should continue, with Public Health providing technical assistance to DHS with implementation.

The memo also indicated that the increased threat of disease outbreaks or bioterrorism points to a need for the union of health care functions. Because Public Health is charged with protecting and safeguarding the health of everyone in Los Angeles County, it works with all hospitals within the

county, with physicians, managed care organizations, clinics and other health services providers. In the event of a serious disease outbreak all facilities must be equally prepared to respond. DHS facilities should be well prepared, and Public Health has and would continue to work with them if a separate Public Health Department were established. However, in the event of an outbreak or emergency, patients are likely to go the closest facility, whether public or private.

The June 9, 2005 CAO report on creating a separate department cites the increased threat of disease outbreak or bioterrorism as one rationale for separation. Aggressive planning and preparation must be done within Public Health now, before an outbreak occurs. However, in the absence of a current crisis, Public Health administrative requests such as hiring, purchasing, and contract development have to compete with the frequent and continuing high visibility and urgent demands from within the DHS hospital system. This has sometimes led to serious delays that affect our preparedness.

Regarding the concern cited in the memo about the overlap in geographic areas served by DHS and those with high public health service needs – this overlap is largely a function of where poverty is most prevalent. Maps of DPSS, DCFS, and DMH clients would likely have the same degree of overlap. Furthermore, the services provided by DHS and Public Health in these areas are different, although related, with DHS focusing on patient care and Public Health focusing on population-based efforts. Coordination among all county departments is critical to develop more effective sets of services and to create conditions that are conducive to health improvements for these vulnerable populations. Unlike personal health within DHS, Public Health's responsibility includes all county residents.

Communication and Advocacy

Both personal health and public health need to deal with the news media on current issues. However, there are additional communication needs that are very specific to public health. The "bully pulpit" aspect of the health officer's role provides a platform to impart positive health messages to the public on critical subjects such as smoking, physical activity, and emergency preparedness. This is the local analog of the Surgeon General role nationally. The ability to link positive health messages with the health officer builds trust in the community, which should have a carryover effect in the actual event of a disaster or health emergency, when the health officer may be issuing emergency instructions.

Both personal health and public health have important advocacy roles. The separation of departments would not preclude the coordination of messages and advocacy positions on areas of shared interest, such as the need for more coverage for the uninsured and reimbursement for necessary health services to this group.

In the event of a bioterrorism attack, communication would be coordinated through the County's Office of Emergency Management, using the incident command structure mandated by the Board. Within this framework, the Health Officer will have the responsibility to communicate key health messages to the public.

Allocation of Resources

I share the concern that current administrative resources are being stretched to meet the needs of DHS and Public Health. However I disagree that the present infrastructure meets the needs of both personal and public health. Rather, the current crisis or high-visibility issue dictates the use of these limited administrative resources. It would be more advantageous for Public Health to set its own priorities for its administrative staff, however limited, rather than always having to compete with urgent priorities such MLK, the 1115 Waiver, hospital financing, and other issues that legitimately require immediate attention.

Furthermore, almost all of the administrative positions that would be moved to Public Health are currently working on Public Health activities. Areas such as contract monitoring have been chronically understaffed, and need to be augmented regardless of whether the departments separate. According to the draft implementation plan, 26 new positions would be added to Public Health, at a cost of $1.7 million, or less than three tenths of one percent of Public Health's budget. Five of the twenty-six positions are related to pharmacy services and will be needed regardless of whether a separate department is created. The only other new positions that would be added to DHS are those to support areas that are already understaffed, and would be needed regardless of separation. The Board motion that approved a separate Public Health Department in concept specified that this needed to be accomplished without an increase in net county cost. We believe that sufficient efficiencies can be achieved to offset the relatively small increase in necessary administrative staffing.

Separate Administrative and Support Functions

While it is true that the County administrative processes are cumbersome, having the additional layer of DHS approval makes the process even more cumbersome. For example, Children's Medical Services and Alcohol and Drug Program Administration have their own procurement processes rather than going through Health Services Administration (HSA) and they order and receive supplies and equipment in a much more efficient and expedited manner than the rest of Public Health, which currently are required to go through HSA.

Competition of Funding

I appreciate the strong support that the current DHS director has given Public Health. However, Public Health sustained cuts totaling $8.8 million as a result of the 2002-03 DHS administrative and programmatic reductions. First, there were administrative consolidations and reductions ($1.3 million net), in which we lost new Board-approved initiatives in chronic disease control and quality assurance and performance monitoring. Since the consolidations, we have not had adequate administrative support in key areas, such as human resources and materials management, because the consolidated units are under-staffed. The office of Planning, which was transferred to DHS, now provides little service to Public Health, because of its nearly exclusive focus on the personal health restructuring.

Second, we sustained programmatic reductions ($7.5 million net) through which we lost any back-up capacity in the staffing for our limited clinical services. Thus, when even a single physician or nurse is absent, clinics sometimes have had to be cancelled.

Other DHS directors might not value Public Health as highly, leaving Public Health vulnerable to more drastic cuts in the future.

Furthermore, in a department where Public Health is a small part, recruitment of a DHS director will always focus on the needs of hospitals and clinics over the broad public health function. In the past, Public Health was allowed to languish, resulting on the 1997 Breslow report, "Report of Review of Public Health Programs and Services, Los Angeles County, Department of Health Services," which documented this decline and recommended a reinvigoration of public health. Fortunately, your Board responded by agreeing to a restructuring of Public Health and the addition of new positions, including a new director. Without strong support from the DHS director, it may also be difficult to recruit for a Public Health director, as the most dynamic candidates may not be willing to report only indirectly to the governing body and may not be willing to work for a director with limited understanding of key public health functions, and/or weak support of public health priorities.

Alternatives

The CAO's June 9, 2005 report addressed the substantive improvements that could result from Public Health's becoming a separate department. On June 28, 2005, the Board approved separation in concept and instructed the CAO to develop a detailed implementation plan and timetable for establishing the new department – thus, subsequent reports have focused on logistical issues.

Separating DHS and Public Health does not preclude a discussion of bolder and more comprehensive structural changes. In some ways, separation makes this discussion easier, as alternatives such as a health authority would require separation as a first step. Similarly, changes to administrative processes or ones that would give more authority to department heads could be discussed regardless of whether the departments separate.

Thank you for the opportunity to discuss these concerns. If you have any questions or need additional information, please let me know.

JEF:wks

c: Thomas L. Garthwaite, MD